

07366

CERTIFICATE OF DEATH

07340

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 337 - 17th Place, N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FRED Middle NMI Last BABB				4. DATE OF DEATH Month July Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 7, 1893	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 1 Days 18 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY GSA-US Government	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Steve Baboy		14. MOTHER'S MAIDEN NAME Irene Baboy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fibrosis of the myocardium due to degeneration and replacement fibrosis DUE TO 491X (c) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 1 - 2 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis general, moderately severe - unknown						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. Month 19 Day 19 Year 19 p. m. VA				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VAH, Perry Point, Md.				(County)		(State)	
21. I certify that I attended the deceased from July 3, 1957 to July 18, 1957 and that death occurred at 3:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler				DATE SIGNED 7-22-57			
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son				ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR Irene E. Dougherty	
DATE 7-23-57				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1-1-1914

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH			
JAMES H. HARRIS		45		M		W		1869		BALTIMORE, MD.			
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH			
1212 N. E. ST.		LABORER		8 YEARS		MARRIED		JULY 25, 1957		BALTIMORE, MD.			
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE		SIGNATURE		DATE		PLACE			
HEART DISEASE		NATURAL		1		JAMES H. HARRIS		JULY 25, 1957		BALTIMORE, MD.			
DETAILS OF DEATH		HISTORY		TESTS		TREATMENT		FOLLOW-UP		REMARKS			
DECEASED WAS FOUND DEAD IN HIS HOME AT 10:30 A.M. ON JULY 25, 1957. HE HAD BEEN SICK FOR SEVERAL DAYS WITH PAIN IN THE CHEST AND SHORTNESS OF BREATH. HE HAD BEEN TAKING MEDICINE BUT IT DID NOT HELP. HE WAS FOUND BY HIS WIFE WHO CALLED THE DOCTOR. THE DOCTOR CAME AND FOUND HIM DEAD. HE WAS TAKEN TO THE HOSPITAL AND AUTOPSY WAS PERFORMED. THE RESULTS OF THE AUTOPSY WERE THAT HE DIED OF HEART DISEASE.		HE HAD BEEN SICK FOR SEVERAL DAYS WITH PAIN IN THE CHEST AND SHORTNESS OF BREATH. HE HAD BEEN TAKING MEDICINE BUT IT DID NOT HELP. HE WAS FOUND BY HIS WIFE WHO CALLED THE DOCTOR. THE DOCTOR CAME AND FOUND HIM DEAD. HE WAS TAKEN TO THE HOSPITAL AND AUTOPSY WAS PERFORMED. THE RESULTS OF THE AUTOPSY WERE THAT HE DIED OF HEART DISEASE.		HE HAD BEEN SICK FOR SEVERAL DAYS WITH PAIN IN THE CHEST AND SHORTNESS OF BREATH. HE HAD BEEN TAKING MEDICINE BUT IT DID NOT HELP. HE WAS FOUND BY HIS WIFE WHO CALLED THE DOCTOR. THE DOCTOR CAME AND FOUND HIM DEAD. HE WAS TAKEN TO THE HOSPITAL AND AUTOPSY WAS PERFORMED. THE RESULTS OF THE AUTOPSY WERE THAT HE DIED OF HEART DISEASE.		HE HAD BEEN SICK FOR SEVERAL DAYS WITH PAIN IN THE CHEST AND SHORTNESS OF BREATH. HE HAD BEEN TAKING MEDICINE BUT IT DID NOT HELP. HE WAS FOUND BY HIS WIFE WHO CALLED THE DOCTOR. THE DOCTOR CAME AND FOUND HIM DEAD. HE WAS TAKEN TO THE HOSPITAL AND AUTOPSY WAS PERFORMED. THE RESULTS OF THE AUTOPSY WERE THAT HE DIED OF HEART DISEASE.		HE HAD BEEN SICK FOR SEVERAL DAYS WITH PAIN IN THE CHEST AND SHORTNESS OF BREATH. HE HAD BEEN TAKING MEDICINE BUT IT DID NOT HELP. HE WAS FOUND BY HIS WIFE WHO CALLED THE DOCTOR. THE DOCTOR CAME AND FOUND HIM DEAD. HE WAS TAKEN TO THE HOSPITAL AND AUTOPSY WAS PERFORMED. THE RESULTS OF THE AUTOPSY WERE THAT HE DIED OF HEART DISEASE.		HE HAD BEEN SICK FOR SEVERAL DAYS WITH PAIN IN THE CHEST AND SHORTNESS OF BREATH. HE HAD BEEN TAKING MEDICINE BUT IT DID NOT HELP. HE WAS FOUND BY HIS WIFE WHO CALLED THE DOCTOR. THE DOCTOR CAME AND FOUND HIM DEAD. HE WAS TAKEN TO THE HOSPITAL AND AUTOPSY WAS PERFORMED. THE RESULTS OF THE AUTOPSY WERE THAT HE DIED OF HEART DISEASE.		HE HAD BEEN SICK FOR SEVERAL DAYS WITH PAIN IN THE CHEST AND SHORTNESS OF BREATH. HE HAD BEEN TAKING MEDICINE BUT IT DID NOT HELP. HE WAS FOUND BY HIS WIFE WHO CALLED THE DOCTOR. THE DOCTOR CAME AND FOUND HIM DEAD. HE WAS TAKEN TO THE HOSPITAL AND AUTOPSY WAS PERFORMED. THE RESULTS OF THE AUTOPSY WERE THAT HE DIED OF HEART DISEASE.	

BUREAU V. 2

JUL 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7367

CERTIFICATE OF DEATH

07341

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 8yrs. 7mo. 3days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3000 Sollers Point Road			
3. NAME OF DECEASED (Type or print) First Middle Last HARRISON C. CADWALLADER				4. DATE OF DEATH Month Day Year July 25 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-4-10	
9. AGE (In years last birthday) 47		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Corporation Edgar Cadwallader				14. MOTHER'S MAIDEN NAME Helen King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Epilepticus, cause unknown 353.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from December 22, 1957, to July 25, 1957, and that death occurred at 3:20 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler				ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.			
PHYSICIAN'S NAME (Type) W. OPPLER				DATE SIGNED 7-26-57			
22a. BURIAL, CREMATION, REMOVAL Removal				22b. DATE THEREOF 7-26-57		22c. NAME OF CEMETERY OR CREMATORY Parkwood	
22d. LOCATION (City, town, or county) Baltimore, Md.				22e. (State)		22f. REC'D BY REGISTRAR	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, North & Penna. Ave.,				23a. ADDRESS Baltimore, Md.		23b. REGISTRAR'S SIGNATURE	

MARTIANO STATE DEPARTMENT OF HEALTH—BIRMINGHAM 18

RECEIVED

JUL 30 1957

BUREAU V. S.

RECEIVED

157



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07342
96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 24 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47x-3	
3. NAME OF DECEASED (Type or print) Samuel Carpenter		f. STREET ADDRESS 5102 5th St., N.W.	
4. DATE OF DEATH Month July Day 29 Year 1957		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-19-91
9. AGE (In years last birthday) 66 yrs.		10. BIRTHPLACE (State or foreign country) Virginia	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Carpenter		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hosp. Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation DUE TO foreign body in larynx (b) 10 minutes DUE TO 10 minutes (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Foreign body in larynx	
20c. TIME OF INJURY Month, Day, Year 5.04 Hour 7-29-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA Hospital		20f. (City or town) Perry Point, Maryland (Cecil)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R. C. Dodson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-30-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 1-57	
22c. NAME OF CEMETERY OR CREMATORY Nash & Slaw Funeral Home, Ninde, Virginia		22d. LOCATION (City, town, or county) Commonwealth of Virginia	
24a. REC'D BY REGISTRAR DATE 7-30-57		24b. REGISTRAR'S SIGNATURE <i>D. S. Doughty</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

1957 1

BUREAU V. 8.

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 15 E. Fort Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First BERNARD		Middle COHEN		Last COHEN	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-4-22	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		4. DATE OF DEATH July		Day 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Cleaning		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hyman Cohen				14. MOTHER'S MAIDEN NAME Rebecca Lahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes PL28		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia due to 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelo Nephritis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-8-57 to 7-30 , 19 57 , and that death occurred at 1:20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Maryland DATE SIGNED 7-30-57 ACTUAL SIGNATURE [Signature] M.D. PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Director, Professional Services, VAH, Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-30-57		22c. NAME OF CEMETERY OR CREMATORY Rosedale		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE JACK LEWIS, Inc. Funeral Home, Baltimore, Md.				24a. REC'D BY REGISTRAR DATE 7-30-57		24b. REGISTRAR'S SIGNATURE Irene E. Daugh...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH August 1, 1957		PLACE OF DEATH Home	
DECEASED John Doe		AGE 45 years	
SEX Male		RACE White	
BIRTH DATE March 15, 1912		BIRTH PLACE Baltimore, Md.	
MARRIAGE Married		EDUCATION High School	
OCCUPATION Teacher		RELIGION Roman Catholic	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Coronary Artery Disease	
FUNDAMENTAL CAUSE Atherosclerosis		PRE-EXISTING DISEASES Hypertension, Diabetes	
DATE OF EXAMINATION August 1, 1957		PLACE OF EXAMINATION Home	
SIGNATURE OF PHYSICIAN Dr. J. K. Smith		SIGNATURE OF DEATH REGISTRAR John Doe	

BUREAU V-2

AUG 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07344

07351

CERTIFICATE OF DEATH

Reg. Dist. No.

97

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>7 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>			
				d. STREET ADDRESS <u>Rising Sun</u>			
3. NAME OF DECEASED (Type or print) <u>Terri</u> First <u>Annie</u> Middle <u>Cole</u> Last				4. DATE OF DEATH <u>July</u> Month <u>19</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1957</u>	9. AGE (In years last birthday) <u>7</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Elkton Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Paul Cole</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Spratt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Paul Cole</u> Address <u>Rising Sun Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature birth - gestation 33 wks.</u> <u>761.5</u> DUE TO <u>weight 3 lbs. - 4 g.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anoxia - cord tightly about neck at birth</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>July 19, 1957</u> , to <u>July 20, 1957</u> , that I last saw the deceased alive on <u>July 20, 1957</u> , and that death occurred at <u>12:15 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u>				ADDRESS (Street, city or town, state) <u>233 E. Main St., Elkton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>				DATE SIGNED <u>7/20/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 21, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Bonds</u>	22d. LOCATION (City, town, or county) <u>Rising Sun, Md.</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Earl Tyson</u>			ADDRESS <u>Rising Sun, Md.</u>			24a. RECEIVED BY REGISTRAR <u>JUL 23 1957</u>	24b. REGISTRAR'S SIGNATURE <u>F. R. Fryer</u>

2065314xVI

● ● ●

JUL 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07345

Reg. Dist. No. **94**

C7370

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE N.Y. b. COUNTY Kings	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.		c. LENGTH OF STAY IN 1b _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn d. STREET ADDRESS 255 Union Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last John Comitini		4. DATE OF DEATH Month Day Year 7 28 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory		10b. KIND OF BUSINESS OR INDUSTRY Doll Stubber	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Comitini		14. MOTHER'S MAIDEN NAME Mary Bruno	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 064-07-0070	
17. INFORMANT Angelina Manduca, 1125 , Forty first St.		Address Brooklyn, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chestn Partial amputation right foot Fracr DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of left femur right forearm and DUE TO (c) Laceration of right side of face.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car pulled across grass plot in front of Bus	
20c. TIME OF INJURY Month, Day, Year 3:35 p.m. 7-28-57 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) (County) (State) North East Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <i>R.C. Dodson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-29-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF July 29-1957	
22c. NAME OF CEMETERY OR CREMATORY St. Raymond		22d. LOCATION (City, town, or county) (State) Bronx New York City N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Hunt North East Maryland</i>		24a. REC'D BY REGISTRAR DATE 7-29-57	
24b. REGISTRAR'S SIGNATURE <i>Sarah E. Rothermel</i>		24c. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

RECEIVED
JUL 13 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07346

07371

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 1mo. 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle I. Last DUBECK		4. DATE OF DEATH Month July Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1911
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PHILIP DUBECK		14. MOTHER'S MAIDEN NAME ANNA SISCO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-11	
17. INFORMANT Unknown		Address Hospital Records, VAH., Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema and Congestion, bilateral, severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma, Gastro-Intestinal Tract and Retro-peritoneal Lymph Nodes. DUE TO (c) Atherosclerosis, Coronary Arteries, severe.		INTERVAL BETWEEN ONSET AND DEATH 4 to 6 hrs. Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 1 p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 14, 1957 , to July 13, 1957 , and that death occurred at 11:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William M Harris M.D.			
PHYSICIAN'S NAME (Type) WILLIAM M. HARRIS, M. D., Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-14-57	
22c. NAME OF CEMETERY OR CREMATORY Bnai Israel Congregation		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE JACK LEWIS, INC.		24a. REC'D BY REGISTRAR 17-14-57	
ADDRESS 2100 Eutaw Place, Baltimore 17, Md.		24b. REGISTRAR'S SIGNATURE Doreen E. Dougherty	

CERTIFICATE OF DEATH

1. Name of deceased John J. Smith		2. Sex Male	
3. Date of birth January 1, 1911		4. Place of birth USA	
5. Date of death July 16, 1957		6. Place of death Johns Hopkins Hospital	
7. Cause of death Myocardial infarction		8. Manner of death Natural	
9. Signature of physician Dr. J. H. Smith		10. Signature of registrar John J. Smith	

BUREAU V. S.

JUL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07347

07352

CERTIFICATE OF DEATH

Reg. Dist. No.

97

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Liberty Grove x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>1</u>	

3. NAME OF DECEASED (Type or print) <u>Roberta Jane</u> First Middle Last		4. DATE OF DEATH <u>July</u> Month <u>19</u> Day <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 Year IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher Public Schools</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liberty Grove Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

13. FATHER'S NAME <u>Theodore</u>		14. MOTHER'S MAIDEN NAME <u>Elga Caldwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Roberta White</u>		Address <u>321 St. Paul St. Baltimore Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>about 1 wk.</u>
---	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1 Arteriosclerotic cardiovascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>July 17</u> , 19 <u>57</u> , to <u>July 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 19</u> , 19 <u>57</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u>	ADDRESS (Street, city or town, state) <u>233 E. Main St., Elkton, Md.</u> DATE SIGNED <u>7/19/57</u>
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>	22d. LOCATION (City, town, or county) (State) <u>Coloma, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson, Presing Len Md.</u>		24a. RECEIVED BY REGISTRAR <u>JUL 23 1957</u>	24b. REGISTRAR'S SIGNATURE <u>A. Tyson</u>

BUREAU V. S.

2 JUL. 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07348

07353

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				e. STREET ADDRESS R.D.3		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roger Lee Graham				4. DATE OF DEATH Month 7 Day 15 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-1957		9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lee Graham				14. MOTHER'S MAIDEN NAME Eloise Muncy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Lee Graham, Elkton, R.D.3 Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diarrhoe 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/57		22c. NAME OF CEMETERY OR CREMATORY Big Creek		22d. LOCATION (City, town, or county) (State) In Harris, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. Henry Pappani				24a. REC'D BY REGISTRAR DATE 7/18/57		24b. REGISTRAR'S SIGNATURE H. R. Trager	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 22 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07349

07354

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Hamilton Last				4. DATE OF DEATH Month 7 Day 10 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-1867		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 7 Days 10	IF UNDER 24 HRS. Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY nothing		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Samuel Hamilton				14. MOTHER'S MAIDEN NAME Susan Riale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Ernest Hamilton, North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of right femur DUE TO Conditions, if any, which gave rise to immediate cause (b) Bilateral Broncho Pneumonia DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell walking down the street.					
20c. TIME OF INJURY Month, Day, Year 6-12-57 Hour 6:35 a. m. 6:35 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) North East (County) Cecil (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 13, 1957		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY West Nottingham Co. Colora, Cecil Md.		22d. LOCATION (City, town, or county) (State) North East Cecil Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson				24a. REC'D BY REGISTRAR 15 1957		24b. REGISTRAR'S SIGNATURE J. R. Lacey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Death

Age

Sex

Color

Place of Birth

28 years

Male

Place of Death

Residence

Home

100

100-100

100

100-100

100-100

100-100

100-100

100-100

100-100

100

100-100

100-100

100-100

BUREAU V. S.

JUL 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 218 7-30-57 et

07355

CERTIFICATE OF DEATH

Reg. Dist. No.

07350

92

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural - Elkton R. D. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First REBA Middle E. Last HAMILTON				4. DATE OF DEATH Month July Day 15 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1874	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry McConnell				14. MOTHER'S MAIDEN NAME Margaret Barclay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 0 m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Elkton				20g. (County) Cecil		20h. (State) Maryland	
21. I certify that I attended the deceased from July 12, 1957 , to July 15, 1957 , that I last saw the deceased alive on July 15, 1957 , and that death occurred at 4:28 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 135 West Main Street DATE SIGNED ACTUAL SIGNATURE Milford H. Sprecher M.D. PHYSICIAN'S NAME (Type) Milford H. Sprecher, M.D. Elkton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Sharps Cemetery		22d. LOCATION (City, town, or county) (State) Cecil County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks Elkton, Maryland				24a. REC'D BY REGISTRAR DATE 7/18/57		24b. REGISTRAR'S SIGNATURE FR Fraser	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT		SURVIVAL		DATE OF SURVIVAL		PLACE OF SURVIVAL		CITY OF SURVIVAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF OTHER	

BUREAU V. S.

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07356

CERTIFICATE OF DEATH

Reg. Dist. No.

07351

92

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Henry</u> First Middle Last <u>HARRIS</u>				4. DATE OF DEATH <u>July 12</u> Month Day Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2 1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Form owner</u>		11. BIRTHPLACE (State or foreign country) <u>Golts Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>V.I.A.</u>							
13. FATHER'S NAME <u>Hansen Harris</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215 329281</u>		17. INFORMANT <u>Mrs. Mrs. Anthony</u> Address <u>Elkton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC NEPHRITIS</u> DUE TO (c) <u>~</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>5 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>54</u> , to <u>JULY 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JULY 12</u> , 19 <u>57</u> , and that death occurred at <u>8:51</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Davis</u>				M.D. <u>CHESAPEAKE CITY MD</u>		DATE SIGNED <u>7/12/57</u>	
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Pippin</u> ADDRESS <u>Elkton, Md</u>				24a. REC'D BY REGISTRAR DATE <u>7/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>IR Frazer</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH	
EDUCATION		RELIGION	
MARRIAGE		PREVIOUS DEATHS	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL HISTORY		MENTAL HISTORY	
LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS	
TREATMENT		POSTMORTEM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. 3

JUL 16 1957

RECEIVED

07372

07352

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 181

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Cecil	MARYLAND	STATE Maryland	COUNTY Harford
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Aberdeen Proving Ground	STREET ADDRESS (If rural, give location) 12x0.2
HOSPITAL OR INSTITUTION OR STREET ADDRESS Daniel			
3. NAME OF DECEASED: (First) (Middle) (Last) Amos Hickman		4. DATE OF DEATH: (Month) (Day) (Year) Dec 20 1957	
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: 7 Dec. 1914
9. AGE last birthday: 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Soldier		10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army	
11. BIRTHPLACE (State or foreign country): Wilmington, Del		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME: William Hickman		14. MOTHER'S MAIDEN NAME: Ida Boyd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes Current		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: Mrs. Ida Miller 221 King Street, Wilmington, Del.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Fracture of cervical spine - C7</u> DUE TO		
Antecedent cause(s) (b) <u>Fracture of cervical spine - C7</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: 7/22/57		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Highway	21c. City or town (County) (State): Chesapeake (Baltimore)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: Dec 20, 1957 6:40 P.M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Auto collision
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.		
SIGNATURE: Orlford H. Spradley		DATE SIGNED: Dec 20
23. BURIAL, CREMATION, REMOVAL (Specify): Removal	DATE THEREOF: 7/22/57	NAME OF CEMETERY OR CREMATORY: Greenview Cemetery
LOCATION (City, town, or county) (State): Wilmington, Delaware	24. FUNERAL DIRECTOR: John G. Tarring	ADDRESS: Aberdeen road
DATE REC'D BY LOCAL REG.: July 23-1957	REGISTRAR'S SIGNATURE: [Signature]	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 26 1957
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07357

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07353

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 Hour 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 117 Bow		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert F Holmes				4. DATE OF DEATH Month Day Year 7 1 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-2-1913		9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Town Officer		11. BIRTHPLACE (State or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Holmes				14. MOTHER'S MAIDEN NAME Annie McDonald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-013543		17. INFORMANT Address Howard Holmes, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Penetrating 38 Caliber Bullet in the 976X DUE TO frontal bone at hair line in line with nose Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) into brain tissue DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with 38 revolver					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 7-1 1957		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Town office		20f. (City or town) (County) (State) Elkton Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-2-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Bank Cemetery		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hickey, Elkton, Md				24a. REC'D BY REGISTRAR DATE 7/5/57		24b. REGISTRAR'S SIGNATURE I R Frazier	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 8 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 219 8-16-57 ams

07373

CERTIFICATE OF DEATH

Reg. Dist. No.

07354

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Bainbridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNTC, Bainbridge, Maryland				d. STREET ADDRESS Dental School, USNTC,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Willian Middle Arthur Last Holthusen				4. DATE OF DEATH Month July Day 4 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-16-39	
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Illinois				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Oscar Holthusen				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1956 - 1957 549 50 2628		17. INFORMANT Navy Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diagnosis Undetermined (ventricular fibrillation?) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Physiological Alteration - Type Unknown DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Unknown Immediate							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4, 1957, to July 4, 1957, that I last saw the deceased alive on D.O.A. July 4, 1957, and that death occurred at 1:17 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED D. H. Souilliaid M.D. U.S. Naval Hospital 7-5-57							
ACTUAL SIGNATURE D. H. Souilliaid				PHYSICIAN'S NAME (Type) D. H. SOUILLIARD LT, MC, USNR Bainbridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal for burial		7-8-57		LOCKPORT CITY CEMETERY		WILL COUNTY, ILLINOIS	
23. FUNERAL DIRECTOR'S SIGNATURE Cecilia Patterson, Son, Perryville, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 7-5-57	
				24b. REGISTRAR'S SIGNATURE Dorothy B. Bramble			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07358

CERTIFICATE OF DEATH

Reg. Dist. No.

07355
92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS R.D.#2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Michael Jackson		4. DATE OF DEATH July 21 19 57	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1957
9. AGE (In years lost birthday) yrs. 8		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Arthur Lee Jackson		14. MOTHER'S MAIDEN NAME Bernice Shivery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Bernice S. Jackson		Address R.D. #2 Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.5 PNEUMONIA - Aspiration DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-15, 1957, to 7-21, 1957, that I last saw the deceased alive on 7-21, 1957, and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Arthur R. Brooks M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-57	
22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin		24a. REC'D BY REGISTRAR DATE 7/25/57	
ADDRESS 259 E. Main St. Elkton, Md.		24b. REGISTRAR'S SIGNATURE FR Frazier	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. JACKSON		MALE		45		JUL 15 1912		BALTIMORE		MD		USA			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
LABORER		HEART DISEASE		NATURAL		2 WEEKS		JUL 25 1957		BALTIMORE		MD		USA	
FAMILY PHYSICIAN		HOSPITAL		NAMES OF PHYSICIANS		DATE OF EXAMINATION		DATE OF SIGNATURE		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR			
DR. J. H. JACKSON		BALTIMORE HOSPITAL		DR. J. H. JACKSON		JUL 26 1957		JUL 26 1957		J. H. JACKSON		J. H. JACKSON			
FAMILY PHYSICIAN		HOSPITAL		NAMES OF PHYSICIANS		DATE OF EXAMINATION		DATE OF SIGNATURE		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR			
DR. J. H. JACKSON		BALTIMORE HOSPITAL		DR. J. H. JACKSON		JUL 26 1957		JUL 26 1957		J. H. JACKSON		J. H. JACKSON			

BUREAU V. S.

JUL 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07356

Reg. Dist. No. **94**

(7374)

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Chester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East R.D.</u>			c. LENGTH OF STAY IN 1b -----		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garden City Chester, Pa. 75X-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----				d. STREET ADDRESS <u>89 Pennsylvania Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Manuel Johnson, Jr.</u>				4. DATE OF DEATH Month Day Year <u>7 28 19 57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>5-12-1951</u>		9. AGE (In years last birthday) <u>6</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Chester, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Munual Johnson, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mae Carol Love</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>George M. Johnson, 89 Pennsylvania Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>850x</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Thrown from boat by explosion</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>7 57 7 28 19 57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>North East River North East Cecil Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				DATE SIGNED <u>7-30-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7-30-1957</u>		22c. NAME OF CEMETERY OR CREMATORY -----		22d. LOCATION (City, town, or county) (State) <u>Chester Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Lunt North East Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 7-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Sarah E. Rothermel</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

AUG 1 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07357

07375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rising Sun Rural</u>		LENGTH OF STAY (in this place) <u>35 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rising Sun Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Theodora Christine Keppel</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 13 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 11, 1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Theodore Winkler</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ida Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Frank Keppel Rising Sun, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 57</u> , to <u>7/13, 1957</u> , that I last saw the deceased alive on <u>7/13, 1957</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M. D. <u>Rising Sun, Md.</u> DATE SIGNED <u>7/15/57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 17, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		LOCATION (City, town, or county) (State) <u>Near Perryville Md.</u>	
24. REC'D BY REGISTRAR DATE <u>JUL 17 57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Rising Sun, Md.</u>			

CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, first, middle)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF TOWNSHIP CLERK

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF STATE CLERK

21. SIGNATURE OF NATIONAL CLERK

22. SIGNATURE OF INTERNATIONAL CLERK

23. SIGNATURE OF UNITED NATIONS CLERK

24. SIGNATURE OF WORLD CLERK

25. SIGNATURE OF GALAXY CLERK

26. SIGNATURE OF UNIVERSE CLERK

27. SIGNATURE OF COSMOS CLERK

28. SIGNATURE OF NATURE CLERK

29. SIGNATURE OF SKY CLERK

30. SIGNATURE OF EARTH CLERK

31. SIGNATURE OF WATER CLERK

32. SIGNATURE OF FIRE CLERK

33. SIGNATURE OF AIR CLERK

34. SIGNATURE OF SPACE CLERK

35. SIGNATURE OF TIME CLERK

36. SIGNATURE OF ENERGY CLERK

37. SIGNATURE OF MATTER CLERK

38. SIGNATURE OF FORCE CLERK

39. SIGNATURE OF MOTION CLERK

39. SIGNATURE OF MOTION CLERK

40. SIGNATURE OF CHANGE CLERK

40. SIGNATURE OF CHANGE CLERK

41. SIGNATURE OF DEATH CLERK

41. SIGNATURE OF DEATH CLERK

42. SIGNATURE OF LIFE CLERK

42. SIGNATURE OF LIFE CLERK

43. SIGNATURE OF LOVE CLERK

43. SIGNATURE OF LOVE CLERK

44. SIGNATURE OF HATE CLERK

44. SIGNATURE OF HATE CLERK

45. SIGNATURE OF WAR CLERK

45. SIGNATURE OF WAR CLERK

46. SIGNATURE OF PEACE CLERK

46. SIGNATURE OF PEACE CLERK

47. SIGNATURE OF TRUTH CLERK

47. SIGNATURE OF TRUTH CLERK

48. SIGNATURE OF LIES CLERK

48. SIGNATURE OF LIES CLERK

49. SIGNATURE OF GOOD CLERK

49. SIGNATURE OF GOOD CLERK

50. SIGNATURE OF EVIL CLERK

50. SIGNATURE OF EVIL CLERK

51. SIGNATURE OF LIGHT CLERK

51. SIGNATURE OF LIGHT CLERK

52. SIGNATURE OF DARK CLERK

52. SIGNATURE OF DARK CLERK

53. SIGNATURE OF KNOWLEDGE CLERK

53. SIGNATURE OF KNOWLEDGE CLERK

54. SIGNATURE OF IGNORANCE CLERK

54. SIGNATURE OF IGNORANCE CLERK

55. SIGNATURE OF WISDOM CLERK

55. SIGNATURE OF WISDOM CLERK

56. SIGNATURE OF FOOLISHNESS CLERK

56. SIGNATURE OF FOOLISHNESS CLERK

57. SIGNATURE OF VIRTUE CLERK

57. SIGNATURE OF VIRTUE CLERK

58. SIGNATURE OF VICE CLERK

58. SIGNATURE OF VICE CLERK

59. SIGNATURE OF BEAUTY CLERK

59. SIGNATURE OF BEAUTY CLERK

60. SIGNATURE OF UGLY CLERK

60. SIGNATURE OF UGLY CLERK

61. SIGNATURE OF HEALTH CLERK

61. SIGNATURE OF HEALTH CLERK

62. SIGNATURE OF SICKNESS CLERK

62. SIGNATURE OF SICKNESS CLERK

63. SIGNATURE OF LIFE CLERK

63. SIGNATURE OF LIFE CLERK

64. SIGNATURE OF DEATH CLERK

64. SIGNATURE OF DEATH CLERK

65. SIGNATURE OF REBIRTH CLERK

65. SIGNATURE OF REBIRTH CLERK

66. SIGNATURE OF RESURRECTION CLERK

66. SIGNATURE OF RESURRECTION CLERK

67. SIGNATURE OF JUDGMENT CLERK

67. SIGNATURE OF JUDGMENT CLERK

68. SIGNATURE OF PUNISHMENT CLERK

68. SIGNATURE OF PUNISHMENT CLERK

69. SIGNATURE OF REWARD CLERK

69. SIGNATURE OF REWARD CLERK

70. SIGNATURE OF GLORY CLERK

70. SIGNATURE OF GLORY CLERK

71. SIGNATURE OF SHAME CLERK

71. SIGNATURE OF SHAME CLERK

72. SIGNATURE OF HONOR CLERK

72. SIGNATURE OF HONOR CLERK

73. SIGNATURE OF DISHONOR CLERK

73. SIGNATURE OF DISHONOR CLERK

74. SIGNATURE OF FAITH CLERK

74. SIGNATURE OF FAITH CLERK

75. SIGNATURE OF UNFAITH CLERK

75. SIGNATURE OF UNFAITH CLERK

76. SIGNATURE OF HOPE CLERK

76. SIGNATURE OF HOPE CLERK

77. SIGNATURE OF DESPAIR CLERK

77. SIGNATURE OF DESPAIR CLERK

78. SIGNATURE OF LOVE CLERK

78. SIGNATURE OF LOVE CLERK

79. SIGNATURE OF HATE CLERK

79. SIGNATURE OF HATE CLERK

80. SIGNATURE OF WAR CLERK

80. SIGNATURE OF WAR CLERK

81. SIGNATURE OF PEACE CLERK

81. SIGNATURE OF PEACE CLERK

82. SIGNATURE OF TRUTH CLERK

82. SIGNATURE OF TRUTH CLERK

83. SIGNATURE OF LIES CLERK

83. SIGNATURE OF LIES CLERK

84. SIGNATURE OF GOOD CLERK

84. SIGNATURE OF GOOD CLERK

85. SIGNATURE OF EVIL CLERK

85. SIGNATURE OF EVIL CLERK

86. SIGNATURE OF LIGHT CLERK

86. SIGNATURE OF LIGHT CLERK

87. SIGNATURE OF DARK CLERK

87. SIGNATURE OF DARK CLERK

88. SIGNATURE OF KNOWLEDGE CLERK

88. SIGNATURE OF KNOWLEDGE CLERK

89. SIGNATURE OF IGNORANCE CLERK

89. SIGNATURE OF IGNORANCE CLERK

90. SIGNATURE OF WISDOM CLERK

90. SIGNATURE OF WISDOM CLERK

91. SIGNATURE OF FOOLISHNESS CLERK

91. SIGNATURE OF FOOLISHNESS CLERK

92. SIGNATURE OF VIRTUE CLERK

92. SIGNATURE OF VIRTUE CLERK

93. SIGNATURE OF VICE CLERK

93. SIGNATURE OF VICE CLERK

94. SIGNATURE OF BEAUTY CLERK

94. SIGNATURE OF BEAUTY CLERK

95. SIGNATURE OF UGLY CLERK

95. SIGNATURE OF UGLY CLERK

96. SIGNATURE OF HEALTH CLERK

96. SIGNATURE OF HEALTH CLERK

97. SIGNATURE OF SICKNESS CLERK

97. SIGNATURE OF SICKNESS CLERK

98. SIGNATURE OF LIFE CLERK

98. SIGNATURE OF LIFE CLERK

99. SIGNATURE OF DEATH CLERK

99. SIGNATURE OF DEATH CLERK

100. SIGNATURE OF REBIRTH CLERK

100. SIGNATURE OF REBIRTH CLERK

101. SIGNATURE OF RESURRECTION CLERK

101. SIGNATURE OF RESURRECTION CLERK

102. SIGNATURE OF JUDGMENT CLERK

102. SIGNATURE OF JUDGMENT CLERK

103. SIGNATURE OF PUNISHMENT CLERK

103. SIGNATURE OF PUNISHMENT CLERK

104. SIGNATURE OF REWARD CLERK

104. SIGNATURE OF REWARD CLERK

105. SIGNATURE OF GLORY CLERK

105. SIGNATURE OF GLORY CLERK

106. SIGNATURE OF SHAME CLERK

106. SIGNATURE OF SHAME CLERK

107. SIGNATURE OF HONOR CLERK

107. SIGNATURE OF HONOR CLERK

108. SIGNATURE OF DISHONOR CLERK

108. SIGNATURE OF DISHONOR CLERK

109. SIGNATURE OF FAITH CLERK

109. SIGNATURE OF FAITH CLERK

110. SIGNATURE OF UNFAITH CLERK

110. SIGNATURE OF UNFAITH CLERK

111. SIGNATURE OF HOPE CLERK

111. SIGNATURE OF HOPE CLERK

112. SIGNATURE OF DESPAIR CLERK

112. SIGNATURE OF DESPAIR CLERK

113. SIGNATURE OF LOVE CLERK

113. SIGNATURE OF LOVE CLERK

114. SIGNATURE OF HATE CLERK

114. SIGNATURE OF HATE CLERK

115. SIGNATURE OF WAR CLERK

115. SIGNATURE OF WAR CLERK

116. SIGNATURE OF PEACE CLERK

116. SIGNATURE OF PEACE CLERK

117. SIGNATURE OF TRUTH CLERK

117. SIGNATURE OF TRUTH CLERK

118. SIGNATURE OF LIES CLERK

118. SIGNATURE OF LIES CLERK

119. SIGNATURE OF GOOD CLERK

119. SIGNATURE OF GOOD CLERK

120. SIGNATURE OF EVIL CLERK

120. SIGNATURE OF EVIL CLERK

121. SIGNATURE OF LIGHT CLERK

121. SIGNATURE OF LIGHT CLERK

122. SIGNATURE OF DARK CLERK

122. SIGNATURE OF DARK CLERK

123. SIGNATURE OF KNOWLEDGE CLERK

123. SIGNATURE OF KNOWLEDGE CLERK

124. SIGNATURE OF IGNORANCE CLERK

124. SIGNATURE OF IGNORANCE CLERK

125. SIGNATURE OF WISDOM CLERK

125. SIGNATURE OF WISDOM CLERK

126. SIGNATURE OF FOOLISHNESS CLERK

126. SIGNATURE OF FOOLISHNESS CLERK

127. SIGNATURE OF VIRTUE CLERK

127. SIGNATURE OF VIRTUE CLERK

128. SIGNATURE OF VICE CLERK

128. SIGNATURE OF VICE CLERK

129. SIGNATURE OF BEAUTY CLERK

129. SIGNATURE OF BEAUTY CLERK

130. SIGNATURE OF UGLY CLERK

130. SIGNATURE OF UGLY CLERK

131. SIGNATURE OF HEALTH CLERK

131. SIGNATURE OF HEALTH CLERK

132. SIGNATURE OF SICKNESS CLERK

132. SIGNATURE OF SICKNESS CLERK

133. SIGNATURE OF LIFE CLERK

133. SIGNATURE OF LIFE CLERK

134. SIGNATURE OF DEATH CLERK

134. SIGNATURE OF DEATH CLERK

135. SIGNATURE OF REBIRTH CLERK

135. SIGNATURE OF REBIRTH CLERK

136. SIGNATURE OF RESURRECTION CLERK

136. SIGNATURE OF RESURRECTION CLERK

137. SIGNATURE OF JUDGMENT CLERK

137. SIGNATURE OF JUDGMENT CLERK

138. SIGNATURE OF PUNISHMENT CLERK

138. SIGNATURE OF PUNISHMENT CLERK

139. SIGNATURE OF REWARD CLERK

139. SIGNATURE OF REWARD CLERK

140. SIGNATURE OF GLORY CLERK

140. SIGNATURE OF GLORY CLERK

141. SIGNATURE OF SHAME CLERK

141. SIGNATURE OF SHAME CLERK

142. SIGNATURE OF HONOR CLERK

142. SIGNATURE OF HONOR CLERK

143. SIGNATURE OF DISHONOR CLERK

143. SIGNATURE OF DISHONOR CLERK

144. SIGNATURE OF FAITH CLER

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07358

07376

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Charlestown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 7				d. STREET ADDRESS Route 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle V Last Kreamle			4. DATE OF DEATH Month July Day 11 Year 1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 2, 1874		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Cooper				14. MOTHER'S MAIDEN NAME Rachel Bryson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Lloyd Cooper, Charlestown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Cirrhosis of Liver 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Renal Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 yrs.?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 581.0							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 June, 1957, to 11 July, 1957, that I last saw the deceased alive on 10 July, 1957, and that death occurred at 10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner		M.D.		ADDRESS (Street, city or town, state) North East Rd		DATE SIGNED 12 July '57	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-1957		22c. NAME OF CEMETERY OR CREMATORY Charlestown		22d. LOCATION (City, town, or county) (State) Charlestown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lea A. Patterson		ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 7-13-57		24b. REGISTRAR'S SIGNATURE Inena E. Longfellow	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

JUL 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07359

C7377

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN TB 5 mos. 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 814 West 2nd. Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle KRIVJANIK Last KRIVJANIK		4. DATE OF DEATH Month July Day 28 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-16
9. AGE (In years lost birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Krivjanik		14. MOTHER'S MAIDEN NAME Anna (Maiden Name Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. PL 28	
17. INFORMANT Hospital Records, VAH, Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis and Cerebral Atrophy DUE TO (c) Encephalitis (Eastern Equine Type)		INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 30 , 19 57 , to July 28 , 19 57 , and that death occurred at 11:20 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7-29-57			
ACTUAL SIGNATURE W. Oppler M.D.			
PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Director, Professional Services, VAH, Perry Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1, 57	
22c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. McGarry		24. REC'D BY REGISTRAR JUL 31 1957	
ADDRESS 2700 Wash St., Wilm., DE.		25. REGISTRAR'S SIGNATURE Jane Dougherty	

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]

AGE: [illegible]

SEX: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Registrar: [illegible]

Signature of Coroner: [illegible]

Signature of Medical Examiner: [illegible]

Signature of Burial Officer: [illegible]

Signature of Minister: [illegible]

Signature of Undertaker: [illegible]

Signature of Cemetery: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

BUREAU V. 3

JUL 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07360
94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE NY b. COUNTY New York			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.		c. LENGTH OF STAY IN 1b -----		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ New York 69X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 560 W 163 St. New York 32			
3. NAME OF DECEASED (Type or print) First Middle Last Robert Irving Lewis				4. DATE OF DEATH Month Day Year 7 28 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-24-26	9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 3	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Op.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Lewis				14. MOTHER'S MAIDEN NAME Anna Singer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W.2 7-24-1926		17. INFORMANT Address Albert Lewis, New York City, N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull and Amputation both legs 816X DUE TO above Ankles. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car went from east lane to west L. and Hit by bus.					
20c. TIME OF INJURY Month, Day, Year 9:35 p.m. 7 28 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) (County) (State) North East Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				DATE SIGNED 7-29-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-27-57		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Brant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE 7-29-57	
						24b. REGISTRAR'S SIGNATURE Sarah E. Pothemel	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 31 1957
BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07361

7379

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 801 Forrest Drive	
3. NAME OF DECEASED (Type or print) First ROY Middle W. Last MIDDLECAMP		4. DATE OF DEATH Month July Day 20 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-95
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Motion Picture	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Middlecamp		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease severe DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 4 - 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x Arteriosclerosis general severe - unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1, 19 32, to July 20, 19 57, and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) VAH, Perry Point, Md.	
PHYSICIAN'S NAME (Type) W. OPPLER		DATE SIGNED 7-23-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 7-23-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Hays de Grace, Md.		24a. REC'D BY REGISTRAR DATE 7-25-57	
		24b. REGISTRAR'S SIGNATURE Doreen E. Langherty	

JUL 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07362
92

Reg. Dist. No.

07359

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 North East</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital, D.O.A.</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Etheridge</u> Last <u>Moore, Jr.</u>				4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-1943</u>		9. AGE (In years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	IF UNDER 24 HRS. Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Boy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>North East, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Etheridge Moore, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Mildred Lucille Brown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Louis E. Moore, Sr. North East, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Neck</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>936.4</u> DUE TO (c) <u>936.4</u> </p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit in the back of the neck and head with baseball</u>					
20c. TIME OF INJURY Month, Day, Year <u>7 9 57</u> Hour <u>2:20</u> P. M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ball Diamond</u>		20f. (City or town) (County) (State) <u>North East Cecil Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>7-10-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-12-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East Cecil Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				24a. REC'D BY REGISTRAR DATE <u>7/13/57</u>		24b. REGISTRAR'S SIGNATURE <u>JR Srazer</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

JUL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07380
CERTIFICATE OF DEATH

07363
96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit Rural</u> c. LENGTH OF STAY IN 1b <u>18 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit Rural</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Jacob</u> <u>Martin</u> <u>Mummert</u>				4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1957</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 14, 1877</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Michael Mummert</u>						14. MOTHER'S MAIDEN NAME <u>Unknown Amanda Sterner</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>204-07-6831</u>		17. INFORMANT Address <u>Mrs. Jacob Mummert Port Deposit, Md. R.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial</u> <u>443X</u> DUE TO <u>Ch Sten</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u>Hypertensive Arteriosclerosis</u> (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>7 days</u> <u>10 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>June 6, 1955</u> , to <u>July 8, 1957</u> , that I last saw the deceased alive on <u>July 7, 1957</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>[Signature]</u> M.D.						ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u>				DATE SIGNED <u>7-12-57</u>					
PHYSICIAN'S NAME (Type)															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 11 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pines Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Newchester Pa.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>						ADDRESS <u>Residing Sun Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 11 1957

BUREAU V. P.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07364

Reg. Dist. No.

07360

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Del. b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b -----		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark 46x-3		✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital, D.O.A.				d. STREET ADDRESS 2 Madison Drive, College Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Robert Murphy Jr.				4. DATE OF DEATH Month Day Year 7 28 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24 1918		9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resturer		10b. KIND OF BUSINESS OR INDUSTRY Ice Cream and Food Del.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William R. Murphy, Sr.				14. MOTHER'S MAIDEN NAME Matilda Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Wm. R. Murphy, Milford, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull and Left Femur 823x DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car hit Tree					
20c. TIME OF INJURY Month, Day, Year 7 28 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) East Main St.		20f. (City or town) (County) (State) Elkton Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-28-57	
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/57		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows		22d. LOCATION (City, town, or county) (State) Milford Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE William Benney Jr.				ADDRESS Milford, Del.		24a. REC'D BY REGISTRAR DATE 8/1/57	
						24b. REGISTRAR'S SIGNATURE J.H. Trager	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral home. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ARMY AND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

S. Anderson Drive, College Park, Md.

BUREAU V. S.

AUG 5 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

97

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS <i>XO Cecilton</i>	
3. NAME OF DECEASED (Type or print) <i>THERESA ANN OLDHAM</i>		4. DATE OF DEATH <i>July 26 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26 1957</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baby</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>Cecilton md.</i>
13. FATHER'S NAME <i>Joseph F. Oldham</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Mason</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Joseph F. Oldham</i>		Address <i>Cecilton md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Failure</i> <i>770.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Erythroblastosis Fetalis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i> <i>7 1/2 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Rh incompatibility, Ageneis at Kidney</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 26 1957</i> to <i>July 26 1957</i> , that I last saw the deceased alive on <i>26 July 1957</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Oldham</i> M.D.		ADDRESS (Street, city or town, state) <i>Cecilton, md.</i> DATE SIGNED <i>28 July 57</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, RELOCAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Buried July 29 1957</i>	<i>July 29 1957</i>	<i>Salina Cem</i>	<i>Salina md.</i>
23. F. M. DIRECTOR'S SIGNATURE <i>Edward Yellow</i>		ADDRESS <i>Millington md.</i>	24a. REC'D BY REGISTRAR <i>J. R. Fyfe</i> DATE <i>JUL 30 1957</i>

2065256 XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One

Form with multiple fields for death certificate information, including name, date, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07362

CERTIFICATE OF DEATH

07366

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSP.				d. STREET ADDRESS UNION HOSP. RD. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KAREN Middle LYN Last PHEASANT				4. DATE OF DEATH Month July Day 18 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 16, 1957		9. AGE (In years lost birthday) 2 yrs. IF UNDER 1 YEAR: Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHESTER F. PHEASANT				14. MOTHER'S MAIDEN NAME CAROL ALICE BELDIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT CHESTER F. PHEASANT Address NORTH EAST Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postnatal aspiration asphyxia and atelectasis 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 40 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from 16 July , 19 57 , to 18 July , 19 57 , that I last saw the deceased alive on 18 July , 19 57 , and that death occurred at 4:05 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huchner				ADDRESS (Street, city or town, state) No. 14 East Rd.		DATE SIGNED 18 July '57	
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 20, 1957		22c. NAME OF CEMETERY OR CREMATORY CHARLESTOWN		22d. LOCATION (City, town, or county) (State) CHARLESTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Henry Pappas				ADDRESS Elkton Md.		24a. REC'D BY REGISTRAR DATE 7/22/57	
				24b. REGISTRAR'S SIGNATURE FRB rager			

2065181XV6

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES J. JONES		M		45		W		1912		NEW YORK		1957		BOSTON		HEART DISEASE		NATURAL		J. J. JONES		J. J. JONES	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	
19. PREVIOUS ILLNESS		20. PREVIOUS SURGERY		21. PREVIOUS TRAUMA		22. PREVIOUS DRUGS		23. PREVIOUS ALCOHOL		24. PREVIOUS TOBACCO		25. PREVIOUS OTHER		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER		29. PREVIOUS OTHER		30. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. 1

JUL 24 1957

RECEIVED

07367
st. No. 92

92

MEDICAL CERTIFICATION

VS. A15ME(5)
SM 9/55

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUL 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07382

CERTIFICATE OF DEATH

07369

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 8yrs/17days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 16 Patapsco			
3. NAME OF DECEASED (Type or print) First MICHAEL Middle L. Last SMITH				4. DATE OF DEATH Month July Day 17 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1894		9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY City Park Dept.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE SMITH				14. MOTHER'S MAIDEN NAME MARY LENTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT Hospital Records, VAH., Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis. DUE TO (c) Cerebral Arteriosclerosis.						INTERVAL BETWEEN ONSET AND DEATH 2 hours. 10 years app. " " "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 30, 1949 , to July 17, 1957 , and that death occurred at 6:24 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. Oppler M.D. V.A. Hospital, Perry Point, Md. 7-17-57							
ACTUAL SIGNATURE W. OPPLER, M.D., Director, Professional Services.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF July 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Funeral Home, Glen Burnie, Maryland.				24a. REC'D BY REGISTRAR DATE July 17, 1957		24b. REGISTRAR'S SIGNATURE Doreen E. Daugherty	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
John J. Smith		Male		45		11-15-1912	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main St., Baltimore, Md.		Carpenter		Myocardial Infarction		Natural	
DATE OF DEATH		PLACE OF DEATH		HOSPITAL		PHYSICIAN	
July 18, 1957		Home		St. Mary's Hospital		Dr. J. H. Jones	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE		TIME	
[Signature]		[Signature]		July 19, 1957		10:30 AM	

BUREAU V. S.

JUL 19 1957

RECEIVED

1234 Main St., Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07370

Reg. Dist. No. 94

C7383

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N.Y. b. COUNTY Queens c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 69X-3 d. STREET ADDRESS 64 St. Edward e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sam Sonnenberg		4. DATE OF DEATH Month Day Year 7-28-1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1910
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Appr. Navy Yd.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Sonnenberg		14. MOTHER'S MAIDEN NAME Irene	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 068-09-6570	
17. INFORMANT Norman Jeffer		Address Brooklyn, N.Y. 4620 Fort Ham.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816X Fractured Skull and Jaw and crushed chest DUE TO (b) lacerated left forearm. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car ran from east lane across west lane hit by bus	
20c. TIME OF INJURY Month, Day, Year 3:35 p.m. 7 28 1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) (County) (State) North East Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		DATE SIGNED 7-29-57	
22a. BURIAL, CREMATION, or other disposition Burial		22b. DATE THEREOF 7-29-1957	
22c. NAME OF CEMETERY OR CREMATORY Beth Israel		22d. LOCATION (City, town, or county) (State) Woodbridge New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Hron		24a. REC'D BY REGISTRAR 7-29-57	
ADDRESS North East, Maryland		24b. REGISTRAR'S SIGNATURE Sarah E. Rothman	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 31

NOV 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07371

Reg. Dist. No. 92

07363

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital. D.O.A.				d. STREET ADDRESS Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stefane Middle Taddei Last				4. DATE OF DEATH Month 7 Day 15 Year 1957			
5. SEX M	6. COLOR OR RACE M	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-1888		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY All kinds of work		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME no information				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-03-1141		17. INFORMANT Address Mrs. Benny Bellowds. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension and Ven. Failure (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 444X							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-15-57			
22a. FORMAL CREMATION <input checked="" type="checkbox"/>		22b. DATE THEREOF JULY 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery		22d. LOCATION (City, town, or county) (State) No. Chesapeake City Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. Henry Pappas		ADDRESS Elkton, Md		24a. REC'D BY REGISTRAR 7/18/57		24b. REGISTRAR'S SIGNATURE FRJ rager	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Case No.

Cell

Section

to give

Union

Union Hospital

Trial

Case No.

1888-1889

1888

No information

No information

201-3-1111 No. 1000 of 1000

London Company

London Company and Van. Kellie

BUREAU V. S.

JUL 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own use.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07364

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07372

Reg. Dist. No.

94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b no time	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital. D.O.A.		d. STREET ADDRESS Abcock Lumber Camp	
3. NAME OF DECEASED (Type or print) James F Waggoner		4. DATE OF DEATH Month 7 Day 4 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer		10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Waggoner		14. MOTHER'S MAIDEN NAME Emma Dotson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Frank Boggs, North East. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE R.C. Dodson M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) R.C. Dodson ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-5-57 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal 22b. DATE THEREOF 7-4-57 22c. NAME OF CEMETERY OR CREMATORY Alvon Methodist Cemetery 22d. LOCATION (City, town, or county) (State) Alvon, Greenbrier Co. West Virginia 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph R. Grant North East, Maryland 24a. REC'D BY REGISTRAR DATE 7-6-57 24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel			

MASSACHUSETTS DEPARTMENT OF HEALTH & WELFARE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07374

C7384

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) Perry Point		c. LENGTH OF STAY IN TB 2 mo. 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Moundsville 85x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 202 Mulberry Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES		Middle E.		Last WELLING		4. DATE OF DEATH Month July	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-8-11	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 45		IF UNDER 24 HRS. Days 26		Hours 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Prison		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Friend Welling				14. MOTHER'S MAIDEN NAME Frances Hayes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid Carcinoma of left bronchus with 163x DUE TO metastasis to lymph nodes and the liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Arteriosclerosis, generalized, moderate.						INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15 , 19 57 , to July 26 , 19 57 . I am a _____ M, from the counties and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE W. Oppler M.D. V.A. Hospital, Perry Point, Md. PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Dir. Prof. Services, VAH, Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-26-57		22c. NAME OF CEMETERY OR CREMATORY unknown		22d. LOCATION (City, town, or county) (State) Moundsville, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE 7-27-57		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 15 1901		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JUL 30 1957		HOSPITAL		NEW YORK		NEW YORK		UNITED STATES		HEART DISEASE		NATURAL		FARMER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. B.

JUL 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07375
94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leslie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x0 North East, R.D.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ralph Ayres Williams, 2nd		4. DATE OF DEATH Month 7 Day 21 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-1949
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School Boy	
11. BIRTHPLACE (State or foreign country) North East, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ralph Ayres Williams, 1st.		14. MOTHER'S MAIDEN NAME Mary M. Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Ralph A. Williams.		Address North East, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped of diving board and missed inner tube and sank	
20c. TIME OF INJURY Month, Day, Year 6. 15 7 21 1957 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pond Leslie Cecil Md.	
20f. (City or town) Leslie Cecil Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-22-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-1957	
22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) North East R.D. 1 Cecil Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East Maryland		24a. REC'D BY REGISTRAR DATE 7-22-57	
		24b. REGISTRAR'S SIGNATURE Sarah E. Kothmer	

BUREAU V. S.

JUL 24 1957

RECEIVED

07365

CERTIFICATE OF DEATH

Reg. Dist. No.

94

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GEORGETOWN</u> 14X22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW W. WILSON</u>		4. DATE OF DEATH Month Day Year <u>JULY 21 1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 27 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN F. WILSON</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE R. WOODALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JOHN F. WILSON</u>		Address <u>GALENA, MD.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acquired Nephrosis</u> DUE TO (c) <u>Arteriosclerotic Kidneys</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>
--	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
--	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to July 21, 1957, that I last saw the deceased alive on July 21, 1957, and that death occurred at 6:10 M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED
Wallace Oberheim M.D. Cecilton, Md 22 July 57

ACTUAL SIGNATURE
Wallace Oberheim

PHYSICIAN'S NAME (Type)
Wallace Oberheim

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GEORGETOWN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>GEORGETOWN, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hellous</u>		24. REC'D BY REGISTRAR <u>23 1957</u>	
ADDRESS <u>Mellington, Md</u>		44b. REGISTRAR'S SIGNATURE <u>J. R. Frazier</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUL 24 1957

RECEIVED